CHAPTER V

BILLING INSTRUCTIONS

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CHAPTER V
BILLING INSTRUCTIONS

REIMBURSEMENT RATES

Reimbursement for case management is based on a monthly fee billed to DMAS by the provider agency for only those contacts made directly by the case manager, not by any individuals supervised by the case manager interacting with the elderly case management recipient. This fee must cover all expenses associated with the delivery of case management services. The reimbursement rate is considered by DMAS as payment in full for all administrative costs that the provider agency incurs. The provider is instructed to submit a bill to DMAS for each month during which client-related case management activities occurred. If services are provided for a full month, the provider will bill $100 per month. If case management is provided for less than a full month, the provider will bill $3.33 per day for each day services are provided. However, in no instance can a provider bill for more than $100 per month. Documentation must be in the recipient's chart indicating the purpose of each contact.

AUTHORIZATION

The Case Management Plan of Care and the first four pages of the Uniform Assessment Instrument (UAI) must be sent to WVMI when the case is accepted for case management. Submission of this form is necessary so that payment for case management services will be authorized. No payment for case management will be made until the form is submitted to WVMI. A form will be returned to the provider as notification that billing may be submitted.

MEDICAID INVOICES FOR CASE MANAGEMENT SERVICES

Providers of Elderly Case Management Services must use the HCFA-1500 (12-90) to bill for services.

Submission of Billing Invoices

Case management providers must submit claims with a beginning date as the first day of the month in which services are rendered and an end date as the last day of the month in which services are rendered. Invoices must include only allowable charges for the number of days for services rendered during the calendar month. Any charges submitted prior to the date authorized by WVMI as the begin date will be rejected. Invoices and adjustments must be submitted in the green-edged, self-addressed envelope provided by DMAS. The provider must retain the provider copy for record keeping. All invoices must be mailed with proper postage; messenger or hand deliveries will not be accepted. Invoices and adjustments should not be mailed to the Department of Medical Assistance Services address; this will only delay processing. The mailing address is:

Department of Medical Assistance Services
Practitioner
P. O. box 27444
Richmond, Virginia 23261-7444

Provider agencies should allow at least three to four weeks for claims processing.

ELECTRONIC SUBMISSION OF CLAIMS

Providers may submit claims by direct dial-up at no cost per claim, using toll-free telephone lines. Electronic Data Interchange (EDI) is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. Most personal, mini, or mainframe computers can be used for electronic billing.

TIMELY FILING OF CLAIMS

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the date of the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive eligibility** – Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely manner, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** – Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he or she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local Department of Social Services (DSS) which specifies that the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the receipt of the notification of the delayed eligibility. A copy of the dated letter from the local DSS indicating the delayed

claim information must be attached to the claim. On the HCFA-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Rejected or Denied Claims** – Rejected or denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  Complete the HCFA-1500 (12-90) invoice as explained under the "Instructions for the Use of the HCFA-1500 (12-90) Billing Form" elsewhere in this chapter.

  Attach written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was initially submitted to Medicaid within the required 12-month period.

  Indicate Unusual Service by entering "22" in Locator 24D of the HCFA-1500 (12-90) claim form.

  Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

  Department of Medical Assistance Services
  Practitioner
  P. O. box 27444
  Richmond, Virginia 23261-7444

Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. **Messenger or hand deliveries will not be accepted.**

- **Exceptions** – The state Medicaid agency is required to adjudicate all claims within 12 months of receipt except in the following circumstances:
  - The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.
  - The claim is related to a Medicare claim which has been filed in a timely manner, and the Medicaid claim is filed within six months of the disposition of the Medicare claim.
  - Medicaid has suspended payment to the provider during an investigation, and the investigation exonerates the provider.
  - The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a

hearing decision, corrective action, or court order to others in the same situation as those affected by it.

- **Accident Cases** – The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid, as the time limit for filing the claim has expired.

The procedures for the submission of these claims are the same as previously outlined. The required documentation must be written confirmation that the reason for the delay meets one of the specified criteria.

REMITTANCE VOUCHER (Payment Voucher)

DMAS sends a remittance voucher with each payment. This voucher is a listing of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five years.

The check is the last item in the envelope. The remittance voucher includes an address sheet which has been added for security purposes. The address sheet contains the provider's name and address. The remittance voucher contains a space for special messages from DMAS.

Participating providers are encouraged to monitor the remittance vouchers for special messages that will expedite notification on matters of concern. This mechanism may be used to alert providers on matters that may relate to:

- Pending implementation of policies and procedures; or
- Sharing clarification on a concern expressed by a provider.

INSTRUCTIONS FOR THE USE OF THE HCFA-1500 (12-90) BILLING FORM

To bill for services, the Health Insurance Claim Form, HCFA-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the HCFA-1500. **The required fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information.**

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), Billing Invoice

The purpose of the HCFA-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (See "Exhibits" at the end of this chapter for a sample of this form.)

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.**
2	**REQUIRED**	**Patient's Name - Enter the name of the recipient receiving the service as it appears on the identification card.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT REQUIRED	Employer's Name or School Name
9d	NOT REQUIRED	Insurance Plan Name or Program Name

Locator		Instructions
10	**REQUIRED**	**Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.) a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**CONDITIONAL**	**Name of Referring Physician or Other Source**
17a	**CONDITIONAL**	**I.D. Number of Referring Physician - Enter the 7-digit Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.**
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Reserved for Local Use
20	NOT REQUIRED	Outside Lab?
21	**REQUIRED**	**Diagnosis or Nature of Illness or Injury - Enter the**

Locator		Instructions
		appropriate ICD-9 CM diagnosis which describes the nature of the illness or injury for which the service was rendered.
22	**CONDITIONAL**	**Medicaid Resubmission - Required for adjustment and void. See the instructions for Adjustment and Void Invoices.**
23	NOT REQUIRED	Prior Authorization Number
24A	**REQUIRED**	**Dates of Service - Enter the from and through dates in a 2-digit format for the month, day, and year (e.g., 05/01/00). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.**
24B	**REQUIRED**	**Place of Service - Enter the 2-digit HCFA code which describes where the services were rendered. See the Place of Treatment Codes list following the instructions for the appropriate code entry.**
24C	**REQUIRED**	**Type of Service - Enter the one-digit HCFA code for the type of service rendered. See the code list following the instructions for the appropriate code entry.**
24D	**REQUIRED**	**Procedures, Services or Supplies** **CPT/HCPCS - Enter the 5-character CPT/HCPCS Code which describes the procedure rendered or the service provided. Use Z9445 for elderly case management services.** Modifier - Enter the appropriate HCPCS/CPT modifiers if applicable. See the list of modifiers following the instructions for the appropriate entry.
24E	**REQUIRED**	**Diagnosis Code - Enter the entry identifier of the ICD-9CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable.**
24F	**REQUIRED**	**Charges - Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if.** **applicable for your service**

Locator		Instructions
24G	**REQUIRED**	**Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to your service.**
24H	**CONDITIONAL**	**EPSDT or Family Plan - Enter the appropriate indicator. Required only for EPSDT or family planning services.** **1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services** **2 - Family Planning Service** **Leave blank if it is not EPSDT/Family Planning.**
24I	**CONDITIONAL**	**EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**
24J	**REQUIRED**	**COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for your service.** **2 - No Other Carrier** **3 - Billed and Paid** **5 - Billed, No Coverage. All claims submitted with a Coordination of Benefits (COB) code of 5 must have an attachment documenting one of the following:** • **The Explanation of Benefits (EOB) from the primary carrier; or** • **A statement from the primary carrier that there is no coverage for this service; or** • **An explanation from the provider that the other insurance does not provide coverage for the service being billed (e.g., this is a claim for surgery and the other coverage is dental); or** • **A statement from the provider indicating that the primary insurance has been canceled.** **Claims with no attachment will be denied for reason**

Locator		Instructions
		495, "Other Insurance Information Missing." Providers who submit claims electronically must indicate a value of "6" in field 38 *(Document Indicator)* of the EA0 record and a value of "B" in field 39 *(Type of Documentation)* to indicate that there is an attachment to this claim. In addition, the HA0 record, *Service Line Narrative*, must contain a narrative description of the information that is on file in your office to support COB code 5 for the claim being submitted.
24K	**REQUIRED**	**Reserved for Local Use - Enter the dollar amount received from the primary carrier if Block 24J is coded "3". See special instructions if required for your service.**
25	NOT REQUIRED	Federal Tax I.D. Number
26	**OPTIONAL**	**Patient's Account Number - Seventeen alphanumeric characters are acceptable.**
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	NOT REQUIRED	Amount Paid
30	NOT REQUIRED	Balance Due
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.**
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered
33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your 7-digit Virginia Medicaid provider number in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code.**

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, HCFA-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 3-digit code identifying the reason for the submission of the adjustment invoice.

- **523 Primary Carrier has made additional payment**
- **524 Primary Carrier has denied payment**
- **526 Patient payment amount changed**
- **527 Correcting service periods**
- **528 Correcting procedure/service code**
- **529 Correcting diagnosis code**
- **530 Correcting charges**
- **531 Correcting units/visits/studies/procedures**
- **532 IC reconsideration of allowance, documented**
- **533 Correcting admitting, referring, prescribing, provider identification number**
- **553 Adjustment is for miscellaneous reasons**

Original Reference Number - Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each HCFA-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

Instructions or he Completion of the Health Insurance Claim Form HCFA-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, HCFA-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 3-digit code identifying the reason for the submission of the void invoice.

542 Original claim has multiple incorrect items
544 Wrong provider identification number
545 Wrong recipient eligibility number
546 Primary carrier has paid DMAS maximum allowance
547 Duplicate payment was made
548 Primary carrier has paid full charge
551 Recipient not my patient
552 Void is for miscellaneous reasons
560 Other insurance is available

Original Reference Number - Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each HCFA-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim.)

PLACE OF SERVICE CODES

HCFA - 1500 CODE

00-10	Unassigned
11	Office location
12	**Patient's home**
13-20	Unassigned
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room – hospital
24	Ambulatory surgical center
25	Birthing center
26	Military treatment center
27-30	Unassigned
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
35-40	Unassigned
41	Ambulance – land
42	Ambulance - air or water
43-50	Unassigned
51	Inpatient psychiatric facility
52	Psychiatric facility - partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57-60	Unassigned
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
63-64	Unassigned
65	End stage renal disease treatment facility
66-70	Unassigned
71	State or local public health clinic
72	Rural health clinic
73-80	Unassigned
81	Independent laboratory
82-98	Unassigned
99	Other unlisted facility

TYPE OF SERVICE CODES

CODE	DESCRIPTION
0	Whole blood
1	**Medical care**
2	Surgery
3	Consultation
4	Diagnostic radiology
5	Diagnostic laboratory
6	Therapeutic radiology
7	Anesthesia
8	Assistance at surgery
9	Other medical items or services
A	Used DME
B	High risk screening mammography
C	Low risk screening mammography
D	Ambulance
E	Enteral/parenteral nutrients/supplies
F	Ambulatory surgical center
G	Immunosuppressive drugs
H	Hospice
J	Diabetic shoes
K	Hearing items and services
L	ESRD supplies
M	Monthly capitation payment for dialysis
N	Kidney donor
P	Lump sum purchase of DME, prosthetics, orthotics
Q	Vision items or services
R	Rental of DME
S	Surgical dressings or other medical supplies
T	Psychological therapy
U	Occupational therapy
V	Pneumococcal/flu vaccine
W	Physical therapy
Y	Second opinion on elective surgery
Z	Third opinion on elective surgery

PROCEDURE MODIFIERS

HCPCS/CPT

TC	Technical Component
22	Unusual services
26	Professional component
50	Bilateral procedure
51	Multiple procedures
52	Reduced services
75	Concurrent care
80	Assistant surgeon
81	Minimum assistant surgeon
82	Assistant surgeon

SPECIAL BILLING INSTRUCTIONS

CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care physician bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. Covered outpatient services excluded from this requirement include: renal dialysis clinic services, routine vision care services, BabyCare services, personal care services (respite care or adult day health care), ventilator-dependent services, EPSDT, and prosthetic services.

All services should be coordinated with the primary health care provider whose name appears on the recipient's eligibility card. Other DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

A physician, covering for the primary care physician or on referral from the primary care physician, treating a restricted recipient must place the primary care physician's Medicaid provider number (as indicated on the recipient identification card) in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted recipient is treated on referral from the primary physician, enter the primary care physician's Medicaid provider number (as indicated on the card) and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted recipient is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

SPECIAL BILLING INSTRUCTIONS

MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, HCFA-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the Medicaid Physician Manual.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a of the HCFA-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

REQUESTS FOR BILLING MATERIALS AND ALL FORMS USED BY PROVIDER AGENCIES

DMAS does not elderly case management providers with HCFA-1500 (12-90) claims forms.

The HCFA-1500 (12-90) can be obtained from the U.S. Government Printing Office. Specific details on purchasing can be obtained by writing to the following address:

U.S. Government Printing Office
Superintendent of Documents
Washington, D.C. 20402

In addition, many local forms printers also supply this form. Contact the printer of choice for further information**.**

The Client Materials Management Unit of the Department of Medical Assistance Services is responsible for the distribution of all forms supplied by DMAS.

The Department of Medical Assistance Services Request for Forms/Brochures (DMAS-161) or Request for Billing Supplies (DMAS-160), as appropriate, must be used by providers to order forms or brochures. (See the "Exhibits" section at the end of this chapter for samples of these forms.) A six-month supply of forms should be ordered at least three (3) weeks prior to the anticipated need.

The Request for Forms/Brochures or Request for Billing Supplies must be submitted to:

DMAS Order Desk
Commonwealth/Martin
3703 Carolina Avenue
Richmond, Virginia 23222

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 329-0727.

COMPUTER-GENERATED INVOICES

Providers wishing approval to submit computer-generated invoices, either on continuous forms, diskette or magnetic tape, should write to:

Coordinator
Electronic Media Claims
FIRST HEALTH Services Corporation
Post Office Box 26228
Richmond, Virginia 23230

INQUIRIES CONCERNING BILLING PROCEDURES

Provider inquiries concerning covered benefits, specific billing procedures, or remittances should be directed to the Medicaid HELPLINE number:

786-6273	Richmond Area
1-800-552-8627	All Other Areas

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays.

EXHIBITS

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PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, MIddle Initial)			3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐				4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐				7. INSURED'S ADDRESS (No., Street)
CITY	STATE		8. PATIENT STATUS Single ☐ Married ☐ Other ☐				CITY STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )		Employed ☐ Full-Time Student ☐ Part-Time Student ☐				ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO				a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐			b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)				b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? ☐ YES ☐ NO				c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ___ 2. ___ 3. ___ 4. ___		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#		

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
REQUEST FOR BILLING SUPPLIES

Name _____ Date _____

Provider Number _____ Contact Person _____

Telephone # (_____) _____
Area Code

Check as appropriate:

_____ Please forward preprinted invoices as indicated below.
_____ Please forward invoices suitable for computer use as indicated below.
_____ Other (See order below.)

Quantity	Dental	
_____	DMAS-701	Invoice
_____	DMAS-702	Invoice Adjustment
_____	DMAS-704	Preauthorization Request
_____	DMAS-703	Envelope
	Home Health Agency	
_____	DMAS-662	Envelope
	Hospital	
_____	DMAS-660	Envelope
	SLH	
_____	SLH-24	Mailing Envelope
	Personal Care	NOT PREPRINTED
_____	DMAS-89	Personal Care Recipient Admissions Envelope
_____	DMAS-93	Invoice
_____	DMAS-94	Invoice Adjustment
_____	DMAS-659	Envelope

Quantity	Pharmacy	
_____	DMAS-173	Drug Claim Ledger
_____	DMAS-228	Drug Claim Adjustment
_____	DMAS-664	Envelope
	Practitioner	
_____	DMAS-663	Envelope
	Title XVIII	NOT PREPRINTED
_____	DMAS-30	(Medicare) Deductible and Coinsurance Invoice
_____	DMAS-31	Invoice Adjustment
	Transportation	NOT PREPRINTED
_____	DMAS-7	Invoice
_____	DMAS-8	Invoice Adjustment
_____	DMAS-9	Verification Form

Please return this form to: DMAS Order Desk
Commonwealth/Martin
3703 Carolina Avenue
Richmond, VA 23222

DMAS-160 R 3/2000
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Department of Medical Assistance Services Request for Forms/Brochures

Name _____ Date _____ Telephone # (_____) _____

Provider Number _____ Contact Person _____

Quantity	Form Number	Form Name
_____	DMAS-5	About Your Medicaid Appeal
_____	DMAS-6B	Answers to Your Questions About the Virginia HIV Premium Assistance Prog.
_____	DMAS-16	Maternity Risk Screen
_____	DMAS-17	Infant Risk Screen
_____	DMAS-20	Consent Form for Release of Information
_____	DMAS-50	Maternal Care Coordinator Record (25/pad)
_____	DMAS-51	Infant Care Coordinator Record (25/pad)
_____	DMAS-52	Care Coordination Service Plan (25/pad)
_____	DMAS-53	Pregnancy Outcome Report (25/pad)
_____	DMAS-54	Infant Outcome Report (25/pad)
_____	DMAS-55	Care Coordination Letter of Agreement (25/pad)
_____	DMAS-70	Practitioner Referral Form
_____	DMAS-77	ICF/MR Utilization Review Assessment
_____	DMAS-77A	Programs/Objective Continuation Sheet
_____	DMAS-80	Patient Intensity Rating System review (50/pad)
_____	DMAS-80A	Personal Care Utilization Review
_____	DMAS-90	Personal Care Aide Record (25/pad)
_____	DMAS-95	UAI Assessment Process
_____	DMAS-95A	UAI Assessment Process (part A only)
_____	DMAS-95B	UAI Assessment Process (part B only)
_____	DMAS-95MI/MR	Supplemental Assessment Process Form, Page 1
_____	DMAS-95MI/MR	Supplemental Assessment Process Form, Page 2
_____	DMAS-96	Nursing Home Pre-Admission Screening Plan
_____	DMAS-97	Plan of Care for Personal Care Services (25/pad)
_____	DMAS-97A	Provider Agency Plan of Care (25/pad)
_____	DMAS-97B	Consumer-Directed Plan of Care
_____	DMAS-99	Community-Based Care Recipient Assessment Report (25/pad)
_____	DMAS-99B	Consumer-Directed Assessment Report
_____	DMAS-100	Request for Supervision in Personal Plan of Care (25/pad)
_____	DMAS-101	MH/MR Service Needs Summary (25/pad)
_____	DMAS-102	DMAS Private Duty Nursing Plan of Care
_____	DMAS-103	Monthly Nursing Status Report
_____	DMAS-113A	Medicaid HIV Services Pre-Screening Assessment
_____	DMAS-113B	Medicaid HIV Waiver Services Prescreening Plan of Care
_____	DMAS-114	AIDS Waiver Authorization Form
_____	DMAS-115	Nutritional Information Form
_____	DMAS-119	Social History Form
_____	DMAS-121	Certificate of Patient Status (50/pad)
_____	DMAS-121-A	Certificate of Patient Rehabilitative Services (50/pad)
_____	DMAS-122	Patient Information R 12/98 (50/pad)
_____	DMAS-125	Rehabilitation Treatment Authorization (25/pad)
_____	DMAS-175	Pharmacist Intervention Report (25/pad)
_____	DMAS-177	Patient Counseling Log (25/pad)
_____	DMAS-201	Notification of Medicaid Transportation Denial
_____	DMAS-212	Title XIX Enrollment (50/pad)
_____	DMAS-213	Newborn Eligibility Report
_____	DMAS-216	DMAS-89
_____	DMAS-300	Respite Care Needs Assessment and Plan of Care
_____	DMAS-301	Adult Day Health Interdisciplinary Plan of Care
_____	DMAS-302	Adult Day Health Care Daily Log

Please return this form to: DMAS Order Desk, Commonwealth/Martin, 3703 Carolina Avenue, Richmond, VA 23222

DMAS 161 R 4/13/2000

Department of Medical Assistance Services Request for Forms/Brochures

Name _____ Date _____ Telephone # (_____) _____

Provider Number _____ Contact Person _____

Quantity	Form Number	Form Name
_____	DMAS-351	Pre-Authorization Request (50/pad)
_____	DMAS-352	Certification of Medical Necessity
_____	DMAS-353	EPSDT Medical History Form
_____	DMAS-353A	EPSDT Screening Documentation Form
_____	DMAS-354	IV Therapy Implementation Form
_____	DMAS-412	Medicaid Request for Psych. Extension Treatment (25/pad)
_____	DMAS-420	Request for Hospice Benefits
_____	DMAS-420A	Request For Hospice Benefits(Continued)
_____	DMAS-421	Hospice Benefits Revocation/Change Statement
_____	DMAS-500	HIPP Application
_____	DMAS-501	HIPP Medical History Questionnaire
_____	DMAS-502	HIPP Employer Verification
_____	DMAS-503	HIPP Policy Holder Information
_____	DMAS-750	Fraud Claim Request
_____	DMAS-751	Notice of Recipient Fraud/Non-Fraud Overissuance
_____	DMAS-1000	Third Party Liability Information Report
_____	DMAS-3004	Sterilization Consent Form
_____	DMAS-3005	Acknowledgement of Receipt of Hysterectomy Information
_____	DMAS-3006	Abortion Certification R 3/99
_____	DMAS-4000	Prosthetic Device Preauthorization Form
_____	DMAS-4001	Physician Certification of Need
Quantity	**Form Number**	**Brochure Name**
_____	SLH-1	Hospital Brochure
_____	DMAS-1	EPSDT Pamphlet
_____	DMAS-2	Virginia Medicaid Handbook
_____	DMAS-14E	MEDALLION Brochure (English)
_____	DMAS-14S	MEDALLION Brochure (Spanish)
_____	DMAS-60	BabyCare (English)
_____	DMAS-61	BabyCare (Spanish)
_____	DMAS-62	BabyCare (Vietnamese)
_____	DMAS-63	BabyCare (Laotian)
_____	DMAS-64	BabyCare (Cambodian)
_____	DMAS-67	Planning Ahead: A Guide for Virginians with Disabilities
_____	DMAS-250	Intro/State-Funded Long-Term Care System
_____	DMAS-251	Adult Care Residences
_____	DMAS-252	AIDS Waiver Services
_____	DMAS-253	Consumer-Directed Personal Attendant Services
_____	DMAS-254	Elderly and Disabled Waiver
_____	DMAS-255	Mental Retardation Waiver
_____	DMAS-256	Nursing Facility Services
_____	DMAS-257	Program of All-Inclusive Care for Elderly (PACE)
_____	DMAS-258	Technology Assisted Waiver
_____	DMAS 350	Virginia Children's Medical Insurance Plan (CMSIP Handbook)
Quantity	**Envelope No.**	**Envelope Name**
_____	DMAS-660	Hospital Inpatient/Outpatient
_____	DMAS-663	HCFA-1500 Mailing
_____	DMAS-89	Personal Care Recipient Admissions
_____	SLH-24	SLH Mailing
Quantity	**MISCELLANEOUS**	**NAME**
_____	3	A Coloring Book for MEDALLION Super Stars
_____	10	I was a Good Patient Today
_____	11	My MEDALLION Doctor is My Friend
_____	12	I'm A MEDALLION Super Star
_____	13	My MEDALLION Doctor Said I Did Great

Please return this form to: DMAS Order Desk, Commonwealth/Martin, 3703 Carolina Avenue, Richmond, VA 23222